DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 0 3

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
June 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1905(a)(26) of the Social Security Act (enacted in Section 4802 of the BBA)

7. FEDERAL BUDGET IMPACT:
a. FFY 01-02 $ 27,870,000*(FFP only
b. FFY 02-03 $ 33,534,000(FFP only

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Pages 19 d & 20 c
Attachment 3.1-A, Page 12
Lim on Attachment 3.1-A, p. 31
Attachment 3.1-B, Page 10
Lim on Attachment 3.1-B, p. 30
Supplement 4 to Attachment 3.1-A, pp 1-8
Supplement 4 to Attachment 3.1-B, pp 1-8

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
N/A

10. SUBJECT OF AMENDMENT:
Implementation of the option to provide PACE services to individuals, 55 years or older, certified as eligible for nursing home care by the State Agency

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review State Plan Amendments

12. SIGNATURE OF STATE AGENCY OFFICIAL: 4/12/02

13. TYPED NAME:
Gail L. Margolis

14. TITLE:
Deputy Director, Medical Care Services

15. DATE SUBMITTED:

16. RETURN TO:
Department of Health Services
714 P Street, Room 1640
Sacramento, CA 95814

Attn: State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
April 12, 2002

18. DATE APPROVED:
September 18, 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
June 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Linda Minamoto

22. TITLE: Associate Regional Administrator
Division of Medicaid

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

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Citation	3.1(a)(1)	Amount, Duration and Scope of Services: Categorically Needy (continued)
1905(a)(26) and 1934	(xii) X	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 4 to Attachment 3.1-A ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage that is in excess of established service limits for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

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Citation			3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (continued)
1905(a)(26) and 1934	(xii)	X	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 4 to Attachment 3.1-B Attachment 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage that is in excess of established service limits for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 4 to Attachment 3.1-A.

__X__ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

_____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
27. Program for All-Inclusive Care for the Elderly (PACE)	PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE services package includes all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team essential for the care of the enrollee. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees and shall provide enrollees access to necessary and covered items and services 24 hours per day, every day of the year.	PACE services shall be available to eligible individuals who meet the age criteria of 55 years old or older, reside in the service area of the PACE program, are certified as eligible for nursing home care by the California Department of Health Services, and meet other eligibility conditions as may be imposed under the PACE program agreement.

**Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE MEDICALLY NEEDY

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 4 to Attachment 3.1-B.

__X__ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

_____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
26. Program for All-Inclusive Care for the Elderly (PACE)	PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE services package includes all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team essential for the care of the enrollee. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees and shall provide enrollees access to necessary and covered items and services 24 hours per day, every day of the year.	PACE services shall be available to eligible individuals who meet the age criteria of 55 years old or older, reside in the service area of the PACE program, are certified as eligible for nursing home care by the California Department of Health Services, and meet other eligibility conditions as may be imposed under the PACE program agreement.

**Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

State of California
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.

The State will set an enrollment limit of 5,850 Medicaid PACE recipients to be funded under the Medicaid program.

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. _X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are: See Supplement 4, Attachment 3.1-A, Page 1.1.

(If this option is elected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. ___ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program).

C. _X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

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Medicaid Eligibility Groups Subject to Institutional Eligibility Rules

Individuals receiving services under the PACE Program are eligible under the following eligibility groups(s) in the California State plan. The State will apply all applicable FFP limits under the plan.

1. _X_ The home and community-based group described under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need PACE services in order to remain in the community, and who are covered under PACE).

   Spousal impoverishment rules are used in determining eligibility for the home and community-based group described at 42 CFR 435.217 but who are receiving services under PACE.

   __X__ A. Yes ____ B. No

   a. _X_ The PACE Program covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need PACE Services in order to remain in the community. The enrollment of beneficiaries for PACE services under this method of determining eligibility will be capped for each fiscal year (see Supplement 4, Attachment 3.1-A, Page 1).

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Regular Post Eligibility

1. _X_ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

   (a). Sec.435.726 – States which do not use more restrictive eligibility requirements than SSI.

   1. Allowances for the needs of the:
      (A) Individual (check one) community rules apply
      1.___ The following standard included under the State plan (check one):
      (a) ___ SSI
      (b) ___ Medical Needy
      (c) ___ The special income level for the institutionalized
      (d) ___ Percent of the Federal Poverty Level_____%
      (e) _X_ Other (specify): An amount which represents the sum of (1) the income standard used to determine eligibility/share of cost and (2) any amounts of income disregarded during the Section 1902 (a)(10)(A)(ii)(VI) eligibility phase. The maximum allowance is $10,000.00 per month.
      2.____The following dollar amount: $_____
      Note:If this amount changes, this item will be revised.
      3.____The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):

1.____ SSI Standard

State of California
PACE State Plan Amendment Pre-Print

2.____ Optional State Supplement Standard
3.____ Medically Needy Income Standard
4.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
5.____ The following percentage of the following standard this is not greater than the standards above:_____% of _____ standard.
6.____ The amount is determined using the following formula:
7._X__ Not Applicable (N/A)

(C) Family (check one):
1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of ____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7._X__ Not applicable (N/A)

(2) Medical and remedial care expenses in 42 CFR 435.726

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Regular Post Eligibility

2.____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735 – States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
   (A) Individual (check one)
   1.____ The following standard included under the State plan (check one):
   (a) ____ SSI
   (b) ____ Medically Needy
   (c) ____ The special income level for the institutionalized
   (d) ____ Percent of the Federal Poverty Level:_____%
   (e) ____ Other (specify):_____
2. ____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
3. ____ The following formula is used to determine the needs allowance.

_____
_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):
1.____ The following standard under 42 CFR 435.121:

_____

2.____ The Medically needy income standard

_____

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

State of California
PACE State Plan Amendment Pre-Print

4.____ The following percentage of the following standard that is not greater than the standards above:_____% of _____
5.____ The amount is determined using the following formula:
_____
_____
6.____ Not applicable (N/A)

(C) Family (check one):
1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of _____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7.____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. X State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under

State of California
PACE State Plan Amendment Pre-Print

Section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a) Allowances for the needs of the:
1. Individual (check one):
(A) _X_ The following standard included under the State plan (check one):
1.____ SSI
2.____ Medically Needy
3.____ The special income level for the institutionalized
4.____ Percent of the Federal Poverty Level:_____%
5._X_ Other (specify):An amount which represents the sum of (1) the income standard used to determine eligibility/share of cost and (2) any amounts of income disregarded during the Section 1902(a)(10)(A)(ii)(VI) eligibility phase. The maximum allowance is $10,000.00 per month.

(B) ____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C) ____ The following formula is used to determine the needs allowance:

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

Because this is the same amount that may be retained by individuals in the community to meet their needs.

State of California
PACE State Plan Amendment Pre-Print

II. Rates and Payments

A.. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon one of the following methodologies. Please attach a description of the negotiate rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service. See Supplement 4, Attachment 3.1-A, Page 7a.

1. X Rates are set at a percent of fee-for-service costs
2. ____ Experience-based (contractors/State's cost experience or encounter data) (please describe)
3. ____ Adjusted Community Rate (please describe)
4. ____ Other (please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

Gary McCollum, ASA, MAAA	Capitation Rate Unit, DHS
Robert Ruderman, ASA, MAAA	Capitation Rate Unit, DHS
Arlene Livingston, FSA, MAAA	Capitation Rate Unit, DHS

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

State of California
PACE State Plan Amendment Pre-Print

Rate Setting Methodology for PACE

Under a risk contract, Medicaid payments to the contractor, for a defined scope of services to be furnished to a defined number of recipients, may not exceed the cost to the State of providing those same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. The Program of All-Inclusive Care for the Elderly (PACE) is a capitated program for individuals who are eligible for placement in a Long-Term Care facility.

Capitation rates for contracts the State has with PACE contractors in a number of different counties are set using a fee-for-service equivalent (FFSE) methodology. The FFSE is calculated for each plan, and then the capitation rate is set at a percentage of the FFSE, not to exceed 100 percent.

The calculation of the FFSE starts with a statewide base cost from a prior period, expressed as a cost per eligible per month. Adjustments are then made which adjust the base cost for the specific plan rate being calculated. The adjustments are for the following items:

1. Demographics – This adjusts for the specific age/sex demographics of a plan.
2. Contract Adjustments – Since plans do not cover all available services in fee-for-service, reductions for those services not covered are accounted for on this line. The specific type of services not covered would include the following: AIDS Waiver Services, In-Home Waiver Services, Nursing Facility Waiver Services, and other items not covered related to children who would not be enrolled under this program.
3. Medicare Adjustments – Because Medicare pays a significant portion of the medical expenses for individuals over 65, the capitation rate is different for individuals who have Medicare coverage and for those who do not. This adjusts for the plan population relative to the statewide base.

This adjusted base cost then needs to be projected into the future. There are two considerations here; legislative changes and trend.

1. Legislative Changes – This evaluates the financial impact of legislation that has been passed or is expected to be enacted.

State of California
PACE State Plan Amendment Pre-Print

2. Trend – This adjustment predicts the affect of all other changes that may take place in the Medi-Cal population and in the medical services arena. Because the Base Costs are for fiscal year 1996/97, it is necessary to project these forward to the rate year. Trend adjustments for AIDS are the same as trend adjustments for Long Term Care. The calculation of trends is made in two parts; number of units used per eligible and cost per unit.

The rate setting methodology for PACE is the FFSE cost per person per month. The capitation rate paid to a PACE Program is 85, 90, or 95 percent of the FFSE costs. The percentage used is mutually agreed to by the State and the PACE Program.

Historically, the start up of California PACE Demonstrations Programs capitation rates were set at 95 percent of the FFSE costs for two years in order to gain experience as a PACE Program prior to applying for a federal waiver and then recalculated at 85 percent of FFSE costs in subsequent years as a PACE Program became more stable and financially self-sufficient.

AltaMed Senior BuenaCare's (SBC) percent of FFS continues to remain at 95 percent since they have not been able to achieve self sufficiency. DHS will consider to reduce SBC's percent of FFS to 85 percent in the future.

Over the last several years, On Lok had experienced increased difficulties in recruiting new in-home care workers. In July 1999, On Lok had to increase its home care worker wages by 25 percent over the salary scale just to match the wages of the In-Home Supportive Services (IHSS) workers in San Francisco who perform tasks comparable to On Lok's in-home care workers. The high cost of these services in San Francisco justified On Lok receiving an increase from 85 percent to 90 percent of the cost of a comparable population. On Lok continues to increase its wages just to remain competitive with the IHSS wages.

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III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

State of California
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.

The State will set an enrollment limit of 5,850 Medicaid PACE recipients to be funded under the Medicaid program.

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. _X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are: See Supplement 4, Attachment 3.1-B, Page 1.1.

(If this option is elected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. ____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II – Compliance and State Monitoring of the PACE Program.

C. _X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

State of California
PACE State Plan Amendment Pre-Print

Medicaid Eligibility Groups Subject to Institutional Eligibility Rules

Individuals receiving services under the PACE Program are eligible under the following eligibility groups(s) in the California State plan. The State will apply all applicable FFP limits under the plan.

1. X The home and community-based group described under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need PACE services in order to remain in the community, and who are covered under PACE).

   Spousal impoverishment rules are used in determining eligibility for the home and community-based group described at 42 CFR 435.217but who are receiving services under PACE.

   X A. Yes _____ B. No

   a. X The PACE Program covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need PACE Services in order to remain in the community. The enrollment of beneficiaries for PACE services under this method of determining eligibility will be capped for each fiscal year (see Supplement 4, Attachment 3.1-B, Page 1).

State of California
PACE State Plan Amendment Pre-Print

Regular Post Eligibility

1. _X_ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

   (a). Sec.435.726 – States which do not use more restrictive eligibility requirements than SSI.

   1. Allowances for the needs of the:
      (A) Individual (check one) community rules apply
      1.___ The following standard included under the State plan (check one):
      (a) ___ SSI
      (b) ___ Medical Needy
      (c) ___ The special income level for the institutionalized
      (d) ___ Percent of the Federal Poverty Level____%*
      (e) _X_ Other (specify): An amount which represents the sum of (1) the income standard used to determine eligibility/share of cost and (2) any amounts of income disregarded during the Section 1902(a)(10)(A)(ii)(VI) eligibility phase. The maximum allowance is $10,000.00 per month.
      2.____ The following dollar amount: $_____
      Note:If this amount changes, this item will be revised.
      3.____ The following formula is used to determine the needs allowance:
      _____
      _____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):

1.____ SSI Standard

State of California
PACE State Plan Amendment Pre-Print

2.____ Optional State Supplement Standard
3.____ Medically Needy Income Standard
4.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
5.____ The following percentage of the following standard this is not greater than the standards above:_____% of _____ standard.
6.____ The amount is determined using the following formula:
7._X__ Not Applicable (N/A)

(C) Family (check one):
1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of _____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7._X__ Not applicable (N/A)

(2) Medical and remedial care expenses in 42 CFR 435.726

State of California
PACE State Plan Amendment Pre-Print

Regular Post Eligibility

2.____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735 – States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
   (A) Individual (check one)
   1.____ The following standard included under the State plan (check one):
   (a) ____ SSI
   (b) ____ Medically Needy
   (c) ____ The special income level for the institutionalized
   (d) ____ Percent of the Federal Poverty Level:_____%
   (e) ____ Other (specify):_____
2. ____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
3. ____ The following formula is used to determine the needs allowance.

   _____
   _____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):
1.____ The following standard under 42 CFR 435.121:

_____

2.____ The Medically needy income standard

_____

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

State of California
PACE State Plan Amendment Pre-Print

4.____ The following percentage of the following standard that is not greater than the standards above:_____% of _____
5.____ The amount is determined using the following formula:
_____
_____
6.____ Not applicable (N/A)

(C) Family (check one):
1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of _____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7.____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3._X__ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under

State of California
PACE State Plan Amendment Pre-Print

Section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a) Allowances for the needs of the:
1. Individual (check one):
(A) _X_ The following standard included under the State plan (check one):
1.____ SSI
2.____ Medically Needy
3.____ The special income level for the institutionalized
4.____ Percent of the Federal Poverty Level:_____%
5._X_ Other (specify): An amount which represents the sum of (1) the income standard used to determine eligibility/share of cost and (2) any amounts of income disregarded during the Section 1902(a)(10)(ii)(VI) eligibility phase. The maximum allowance is $10,000.00 per month.

(B) ____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C) ____ The following formula is used to determine the needs allowance:

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

Because this is the same amount that may be retained by individuals in the community to meet their needs.

State of California
PACE State Plan Amendment Pre-Print

II. Rates and Payments

A.. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon one of the following methodologies. Please attach a description of the negotiate rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service. See Supplement 4, Attachment 3.1-B, Page 7a.

1. X Rates are set at a percent of fee-for-service costs
2. ____ Experience-based (contractors/State's cost experience or encounter data) (please describe)
3. ____ Adjusted Community Rate (please describe)
4. ____ Other (please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

Gary McCollum, ASA, MAAA	Capitation Rate Unit, DHS
Robert Ruderman, ASA, MAAA	Capitation Rate Unit, DHS
Arlene Livingston, FSA, MAAA	Capitation Rate Unit, DHS

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

State of California
PACE State Plan Amendment Pre-Print

Rate Setting Methodology for PACE

Under a risk contract, Medicaid payments to the contractor, for a defined scope of services to be furnished to a defined number of recipients, may not exceed the cost to the State of providing those same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. The Program of All-Inclusive Care for the Elderly (PACE) is a capitated program for individuals who are eligible for placement in a Long-Term Care facility.

Capitation rates for contracts the State has with PACE contractors in a number of different counties are set using a fee-for-service equivalent (FFSE) methodology. The FFSE is calculated for each plan, and then the capitation rate is set at a percentage of the FFSE, not to exceed 100 percent.

The calculation of the FFSE starts with a statewide base cost from a prior period, expressed as a cost per eligible per month. Adjustments are then made which adjust the base cost for the specific plan rate being calculated. The adjustments are for the following items:

1. Demographics – This adjusts for the specific age/sex demographics of a plan.
2. Contract Adjustments – Since plans do not cover all available services in fee-for-service, reductions for those services not covered are accounted for on this line. The specific type of services not covered would include the following: AIDS Waiver Services, In-Home Waiver Services, Nursing Facility Waiver Services, and other items not covered related to children who would not be enrolled under this program.
3. Medicare Adjustments – Because Medicare pays a significant portion of the medical expenses for individuals over 65, the capitation rate is different for individuals who have Medicare coverage and for those who do not. This adjusts for the plan population relative to the statewide base.

This adjusted base cost then needs to be projected into the future. There are two considerations here; legislative changes and trend.

1. Legislative Changes – This evaluates the financial impact of legislation that has been passed or is expected to be enacted.

State of California
PACE State Plan Amendment Pre-Print

2. Trend – This adjustment predicts the affect of all other changes that may take place in the Medi-Cal population and in the medical services arena. Because the Base Costs are for fiscal year 1996/97, it is necessary to project these forward to the rate year. Trend adjustments for AIDS are the same as trend adjustments for Long Term Care. The calculation of trends is made in two parts; number of units used per eligible and cost per unit.

The rate setting methodology for PACE is the FFSE cost per person per month. The capitation rate paid to a PACE Program is 85, 90, or 95 percent of the FFSE costs. The percentage used is mutually agreed to by the State and the PACE Program.

Historically, the start up of California PACE Demonstrations Programs capitation rates were set at 95 percent of the FFSE costs for two years in order to gain experience as a PACE Program prior to applying for a federal waiver and then recalculated at 85 percent of FFSE costs in subsequent years as a PACE Program became more stable and financially self-sufficient.

AltaMed Senior BuenaCare's (SBC) percent of FFS continues to remain at 95% percent since they have not been able to achieve self-sufficiency. The Department of Health Services will consider to reduce SBC's percent of FFS to 85 percent in the future.

Over the last several years, On Lok had experienced increased difficulties in recruiting new in-home care workers. In July 1999, On Lok had to increase its home care worker wages by 25 percent over the salary scale just to match the wages of the In-Home Supportive Services (IHSS) workers in San Francisco who perform tasks comparable to On Lok's in-home care workers. The high cost of these services in San Francisco justified On Lok receiving an increase from 85 percent to 90 percent of the cost of a comparable population. On Lok continues to increase its wages just to remain competitive with the IHSS wages.

PACE State Plan Amendment Pre-Print

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.